Appendix C
Prior Authorization

Introduction

Prior authorization (PA) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require PA and some may begin prior to requesting authorization.

Purpose of Prior Authorization

The purpose of prior authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Prior authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Prior authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Prior authorization is performed by DMAS or by a contracted entity.

General Information Regarding Prior Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for PA requests.

The PA entity will approve, pend, reject, or deny all completed PA requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to staff for review. When a final disposition is reached the individual and the provider is notified in writing of the status of the request. If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice will identify the recipient's right to appeal the denial, in accordance with 42 CFR §200 *et seq* and 12 VAC 30-110 *et seq*. The provider also has the right to appeal adverse decisions to the Department.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care program, the PA entity is able to receive monthly information from and provide monthly information to the Medicaid managed care organizations (MCO) or their subcontractors on services previously authorized. The PA entity will honor the Medicaid MCO prior authorization for services and have system capabilities to accept PAs from the Medicaid MCOs.

Communication

Provider manuals are posted on the DMAS and contractor's websites. The contractor's website outlines the services that require PA, workflow processes, criterion utilized to make decisions,

contact names and phone numbers within their organization, information on grievance and appeal processes and questions and answers to frequently asked questions.

The PA entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the PA process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual.

The MMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination. The following chart shows the entity that receives letters generated from MMIS:

	Provider	**Enrolled Individual**	**Comments**
Approval	X	X	
Denial/Partial Denial	X	X	Appeal Rights are included in all denials/partial denials
Pends	X	X	Applies to DMAS generated PAs
Rejects	X	X	Applies to DMAS generated PAs

DMAS will not reimburse providers for dates of service prior to the date identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individuals file, and are subject to review during Quality Management Review (QMR).

Except when Medicare is the primary payor, when more that five visits are medically necessary, the provider must request Prior Authorization. When a recipient has Medicare Part B coverage, Prior Authorization is not required. If Medicare denies the claim, the provider may request authorization as a retrospective review. This is the only time that a retrospective review is allowed, and it must be done within 30 days of the notification of the Medicare denial.

The purpose of Prior Authorization (PA) is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Prior Authorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

Prior Authorizations are specific to a recipient, a provider, a service code, an established quantity of units, and for specific dates of service. If Prior Authorization is required, Prior Authorization must be obtained regardless of whether or not Medicaid is the primary payor, except for Medicare crossover claims. The DMAS PA contractor will not accept reviews for recipients who

have Medicare Part A. If Medicare denies the requested stay, the provider may submit a Prior Authorization request for retrospective review, along with the explanation of benefits (EOB) of denial. This request must be submitted to the DMAS PA contractor within 30 days of the Medicare denial.

PRIOR AUTHORIZATION OF ELDERLY CASE MANAGEMENT SERVICES:

General Information

Prior to requesting authorization of Elderly Case Management (ECM) services the individual must be deemed Medicaid eligible by the Department of Social Services (DSS) and meet program criteria. An individual may be enrolled in a Home and Community Based Waiver and receive ECM services, as long as there is no duplication of services. A Medicaid recipient residing in a Nursing Facility may be authorized to receive ECM services within the guidelines and limitations specified in Chapter IV of the Elderly Case Management Services Manual.

The contractor will accept requests via direct data entry (DDE), by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. The contractor has one business day to process requests from the date the request is received. Specific information regarding the methods of submission may be found at the contractor's website, dmas.kepro.org. The program will take you through the steps needed to receive approval for service requests.

They may also be reached by phone at:

Telephone: 1-888-VAPAUTH
1-888-827-2884

Fax: 1-877OKBYFAX
1-877-652-9329

The following chart shows the information necessary to process the request for case management services. Although these same forms may not be required by the contractor, pertinent information from these forms will be required to process the request. Upon QMR of the provider or case management agency, the forms must be present in the record and fully completed. These documents will be compared against the information submitted to the contractor.

HCPCS Code	Description	PA Required	PA Units Requested	PA Units Approved	Service limits	Units	Forms currently submitted for authorization
T1016	Case Management	Y	Month	Month	31/month, max 6 month auth. Extensions may be requested if needed**	Units	UAI pages 1-4, Plan of Care

** All forms are located on the DMAS web site at www.dmas.virginia.gov.*

*** See Chapter IV*

PRIOR AUTHORIZATION RECONSIDERATIONS and APPEALS PROCESS

Provider Appeals

For Services Prior Authorized by DMAS:
If services are denied by DMAS staff, the provider may request a reconsideration of the denial by writing:

PA Supervisor
Department of Medical Assistance Services
600 East Broad Street, 10th Floor
Richmond, VA 23219

FAX: 1-804-371-4986

For Services Prior Authorized by the PA Contractor:
If services are denied by the preauthorization analyst through the PA Contractor, an automatic reconsideration process will be conducted by a physician reviewer and the provider will be notified of the outcome of the decision.

After completion of the reconsideration process, the denial of Prior Authorization for services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial. If the Prior Authorization denial is for a service that has already been rendered, the provider may appeal the denial in writing within 30 days of the written notification of denial of the reconsideration. Written appeals must be addressed to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Recipient Appeals

The provider may not bill the recipient for covered services that have been provided and subsequently denied by DMAS or the PA contractor.

If the denied services have not been provided, the denial may be appealed by the recipient or by the recipient's authorized representative. For additional information on recipient appeals, refer to the appeals section of Chapter IV of this manual.